# CORE 400 LLC

240 Commercial Street, Suite D
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**DATE OF REVIEW:** DECEMBER 2, 2008

**IRO CASE #:**

## DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for Anterior/Posterior lumbar interbody fusion at L5-S1; length of stay two days

## A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

MD, Board Certified Orthopedic Surgeon

## REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒Upheld (Agree)

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for Anterior/Posterior lumbar interbody fusion at L5-S1; with 2 days inpatient stay.

## INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office Note, Dr., 08/13/07, 08/20/07, 08/24/07, 08/28/07, 09/11/07 and 10/09/08
MRI Report, 09/07/07
Electrodiagnostic Study, 09/13/07
Office Note, Dr., 10/03/07, 1/14/07 and 09/17/08
CT/ Discogram Report, 10/29/07
Radiology Report, 10/29/07

Psychiatric Evaluation, 12/11/07
Letter, 12/27/07
Texas Department of Insurance –Decision and Order, 07/02/08
Appeal Letter, Dr., 10/10/08
ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 10/9/08, 10/20/08

## PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old male who fell going down the steps on xx/xx/xx and reported a pop with acute onset of low back pain. The claimant has a history significant for right L5-S1 hemilaminectomy in 2007 with resolution of his symptomatology and as of the date of injury was a smoker. Evaluation by occupational medicine on 08/13/07 noted lumbar guarding, spasm, tenderness and dysesthesias down the right leg. The claimant treated with a lumbar corset, Celebrex, Zanaflex and Vicodin. On 08/20/07 he continued to have significant pain and started Ultram and Prednisone. On 08/24/07 he was noted to be using a transcutaneous electrical neurostimulator and was started on physical therapy. MRI evaluation on 09/07/07 noted L5-S1 eight millimeter recurrent disc bulge adjacent to the right S1 nerve root, bilateral foraminal stenosis, severe disc disease, disc osteophyte complex and moderate bilateral facet hypertrophy; L4-5 degenerative changes with central protrusion and annular tear as well as bilateral foraminal narrowing and moderate bilateral facet hypertrophy; and L3-4 degenerative changes with small protrusion and mild facet hypertrophy. Electrodiagnostic studies completed on 09/13/07 identified right L5 radiculopathy with bilateral S1 radiculopathy greater on the right affecting the right medial gastroc; right tibial motor neuropathy; and possible spinal stenosis with nerve root impingement at the right L5 and S1. Neurosurgical evaluation on 10/03/07 demonstrated right gastroc weakness at 4/5; right ankle reflex at 1+ with the rest being 2+; antalgic gait with difficulty heel and toe walking; positive bilateral straight leg raise; and hypoesthetic right S1 distribution. Dr. interpretation of the MRI indicated large recurrent disc at L5-S1 with severe right foraminal stenosis and lateral recess stenosis; as well as four to five millimeter disc at L4-5 with bilateral foraminal stenosis that he noted was greater on the left. The claimant continued physical therapy and medications.

Lumbar CT/ discogram conducted on 10/29/07 revealed normal L2-3 level; L3-4 concordant pain with posterior annular tear and extravasation; L4-5 focal disc herniation of one centimeter with severe concordant pain and both posterior and anterior annular tears and extravasation; and L5-S1 severely degenerated disc with near complete loss of height, right focal protrusion of 1.3 centimeters, vacuum disc phenomenon, impingement on right S1 nerve root with mass effect, and severe concordant pain. Dynamic radiographs performed on 10/29/07 indicated severe disc disease at L5-S1 with no subluxation on flexion or extension. Dr. noted failure of conservative modalities included physical therapy and epidural steroid injections. A psychiatric evaluation completed on 12/11/07 reported no signs of depression and anxiety with clearance to undergo surgery. On 12/27/07 Dr. received approval for L5-S1 anterior lumbar interbody fusion with two day length of stay. There was a gap in records until 07/02/08.

A Texas Department of Insurance Decision dated 07/02/08 extended the xx/xx/xx compensable injury to include the lumbar recurrent disc. Dr. evaluated the claimant again on 09/17/08 with notation the claimant has had no significant improvement since the 11/14/07 visit with persistent pain, numbness and weakness with the same examination findings. Dr. again recommended surgical intervention after medical clearance with notation the claimant had been smoke free for six weeks. The claimant then apparently was hospitalized for three days starting 09/26/08 for a gastrointestinal bleed. The claimant also noted he had to stop his pain medication due to liver problems. He had been started on Lorazepam by his primary care physician and was no longer taking anti-inflammatories. On 10/09/08, Dr. indicated the need for medical clearance prior to surgery and gave the claimant Lortab. Surgical intervention continues to be requested.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

Request was for an anterior/posterior lumbar interbody fusion at L5-S1 with a two day length of stay. The claimant underwent a prior L5-S1 right laminotomy. It was felt he had a recurrent herniated nucleus pulposus at L5-S1. There was no evidence of segmental instability. The reviewer is unable to determine from the records provided for the review why the request was made for L5-S1 when discography appears to be concordant at multiple levels. The reason for the procedure was not adequately outlined in the information reviewed. There was no evidence of segmental instability. The indications for the surgery were not adequately outlined per ODG guidelines in the information reviewed. The reviewer finds that medical necessity does not exist for Anterior/Posterior lumbar interbody fusion at L5-S1; length of stay two days.

Milliman Care Guidelines, Twelfth Edition; Lumbar- Fusion
Official Disability Guidelines Treatment in Worker's Comp 2008 Updates; Low Back-Fusion
Patient Selection Criteria for Lumbar Spinal Fusion:
For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (relative angular motion greater than 20 degrees). (Andersson, 2000) (Luers, 2007)] (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (lumbar inter-segmental movement of more than 4.5 mm). (Andersson, 2000)] (4) Revision Surgery for failed previous operation(s) if significant functional gains are

anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Discectomy.)
Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (Colorado, 2001) (BlueCross BlueShield, 2002)

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**